Appropriateness of Assessment and Treatment Interventions for Refugees and Immigrant Children and Youth with Mental Health Issues from Clinicians' Perspectives

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Abstract

The population of immigrants and refugees has drastically increased in Canada in the last few decades. We are currently facing a refugee crisis around the world. In 2015, Canada welcomed 25,000 refugees who have fled from war in their home countries. Refugee families and their children experience significant loss, trauma, and emotional upheaval during the immigration process and this may significantly impact their mental health. Therefore, refugee children and youth need mental health support that can meet their complex and multifaceted issues such as poverty, housing, employment, language and cultural barriers, others.

This study used an exploratory, qualitative, cross-sectional, inductive research design. The data were collected through five semi-structured interviews using the general interview guide approach. The study explores from the clinicians' perspective of the *cultural appropriateness* of assessment and treatment interventions for refugee and immigrant children and youth with mental health issues. The findings point to gaps in mental health services that may create barriers and prevent immigrant and refugee children from accessing appropriate and effective mental health treatment.

Findings from the study indicate that refugee and immigrant children and youth have multilayered issues that need to be addressed holistically. Child and Youth mental health services can improve their services to be culturally appropriate by providing health care providers with cross-cultural training and adequate resources that can meet their client's specific needs.

Keywords: refugees, immigrants, trauma, mental health, appropriate resources, gaps.

Introduction

Cultural diversity has grown considerably in Canada over the past 20 years, and the proportion of the visible minority groups has increased faster even among children and youth (Davis, 2006). The ethno-cultural diversity of Canada's population will increase significantly by 2031 (Statistics Canada, 2011). The vast majority (96%) of Canadians belonging to a visible minority group will likely live in one of the metropolitan areas, and visible minority groups could include 63% of the population of Toronto, 59% of Vancouver and 31% of Montréal (Statistics Canada, 2011). By 2031, nearly half (46%) of Canadians aged 15 and older could be foreign-born, or could have at least one foreign-born parent, up from 39% in 2006 (Statistics Canada, 2011).

Canada continues to help with the current refugee crisis and "25,000 Syrian refugees will be resettled in Canada in 2016, with nearly 3,000 of them coming to BC" (Immigrant Services Society of BC, 2015). Furthermore, "12 million Syrian refugees fled their country because of war and half of them are children" (Immigrant Services Society of BC, 2015). According to the TC (Tri-City) News (2015) "600 Syrian refugees, including 200 children will be resettling in Coquitlam, BC." by the end of the year. It has been estimated that about 2/3 of Syrian refugees may require trauma-focused supports (Immigrant Services Society of BC, 2015).

Approximately, one in five visible minority in British Colombia has been affected by mental illness and addiction ("BC Partners for Mental Health and Addictions," 2006, p. 1). Many studies show that immigrant and refugee children and youth are at risk for mental health and substance abuse issues (e.g., Barozzino, 2010; Nickerson, et al., 2011; Crowley, 2009; Kirmayer,

et al., 2010; Pumariega, Roegrs, & Rothe, 2005; Ngo, 2009; Hansson, Tuck, Laurie, & McKenzie, 2010; Sirin, Ryce, Gupta, & Sirin, 2013; Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011; BC Partners for Mental Health and Addictions, 2006). Pre and post migratory stress, and traumas such as war, torture, rape, natural disasters, and cultural and religious genocides increase the risk for developing mental health issues for minority populations (Hansson, et al., 2010; Gushulak, et al., 2011). However, many minority children and youth confront a number of barriers to effective mental health care (Pumariega, Rogers, & Rothe, 2005; Ngo, 2009; Gushulak, et al., 2011; BC Partners for Mental Health and Addictions, 2006; Barozzino, 2010; Fantino & Colak, 2001; "Centre for Addiction and Mental Health", 2009; Ng, Popova, Yau, & Sulman, 2007). These barriers could be associated with population factors, care provider factors, and systemic factors such as socio-economic inequalities, lack of health education, stigma, poor commitment, lack of cross cultural knowledge and skills, poor accessibility to community resources, training, and lack of culturally competent services. (Pumariega, et al., 2005; Ugiagbe & Eweka, 2014; Gushulak, et al., 2011; BC Partners for Mental Health and Addictions, 2006; Barozzino, 2010).

Due to the changing socio-cultural environment in Canada, cultural competence is a necessity for mental health professionals to stay pertinent and be responsive to the multifaceted needs of immigrant and refugee children and adolescents. These clients are entitled to services that are appropriate to their specific needs. Services that are sensitive to the needs of different cultural groups will be more engaging, will encourage minorities to get treatment, and will improve outcomes (Davis, 2006; Ng, et al., 2007; Stanley, Huey, & Polo, 2008).

In addition, Ngo (2009) argues that Canadian institutions and service organizations need to examine their commitment to social justice by allocating adequate and equitable resources and funding to support children of immigrant families to deal with their multi-faceted needs and also to facilitate their access to decision making process that impact their mental health.

The focus of this study is to explore the appropriateness of assessment and treatment interventions for refugee and immigrant children and youth with mental health issues from the perspective of mental health clinicians. This study refers to appropriateness as mental health services and programs that are culturally and linguistically suitable to the needs of immigrant and refugee children and youth (Barozzino, 2010; Davis, 2006). Culturally appropriate programs and their effectiveness for the mental health wellbeing of refugee and immigrant children and youth will be discussed later. Throughout this study, the terms "minority" and "immigrant and refugee" are used interchangeably; however, my focus is only on refugee and immigrant children and youth. This research will explore how mental health services are structured and delivered with respect to potential clients from immigrant and refugee groups and it is hoped that this will help the social workers who work with these populations in different settings such as school, foster care, child protection, the criminal justice system, health care, and others.

My personal and professional experiences inspired me to look deeper into the issues that refugee and immigrant youth are facing. My own lived experiences as an immigrant and my professional experiences working with immigrant and refugee adult clients with mental health issues has helped me to have a deeper understanding of the cultural and specific needs of the refugee and immigrant population. The following literature review reveals that most immigrant

and refugee clients have experienced some or all faces of oppression through pre and post stages of immigration that has significantly affected their emotional and mental health.

Literature Review

Studies show that immigrant and refugee children and youth are at risk for various mental health concerns, including Post Traumatic Stress Disorder (PTSD), depression, behavioral problems, and substance abuse issues (Barozzino, 2010; Davis, 2006; Nickson, et al., 2011; Crowley, 2009; Kirmayer et al., 2010; Pumariega, et al., 2005; Ngo, 2009; Hansson, et al., 2010; Sirin, et al., 2013; Gushulak, et al., 2011; BC Partners for Mental Health and Addictions, 2006; Whitley & Gould, 2010). Crowley (2009) states, "depression and anxiety are the two variables that have been widely studied as potential psychological outcomes in the child and adolescents refugee population" (p. 324). Other mental health issues reported are self-harming behaviour, poor general health, peer problems, developmental disability, autism, schizophrenia, obsessive compulsive disorder, attention seeking behavior, aggression, illegal behaviour, and pscyho-somatic issues (Crowley, 2009; Nickson et al. , 2011; Florence, 2009). The literature indicates that refugee children may experience greater levels of psychological disturbance than immigrant children such as major depressive disorder and post-traumatic stress disorder, especially for refugee children who have experienced traumatic events in their home country such as war, displacement, grief, loss, forced separation from family, persecution, dangerous escape, and long stay in refugee camps (Fantino & Colak, 2010; Whitley & Gould, 2010).

According to Baughman, Aultman, Ludwick, & O' Neil (2014) "immigrant children have been rated by their teachers to be more emotionally maladjusted" (p. 240). It has been argued

that children of immigrants have some kind of social or emotional adjustment problems and children of families that were better integrated to the Canadian life had less problems (Baughman et al., 2014). Immigrant students have been reported by their teachers to show more anxiety, aggressive outburst, high frustration, low self-confidence, dependency, and conflicts with peers (Baughman, et al., 2014). Racism, discrimination, social isolation, cultural conflicts, low socio-economic status, role change, and identity conflicts are contributing risk factors for the physical and mental health of immigrants (Barozzino, 2010; Baughman, et al., 2014; Sirin, et al., 2013; Lipsicas and Makenines, 2010; Hansson, et al., 2010).

Lipsicas and Makenines (2010) explain that the impact of migration on the mental health of children and youth is a significant social problem that has attracted the attention of many scientists and researchers. In their study, they describe the relationship between suicide and immigration through acculturation and acculturation stress experienced by the immigrants. "Acculturation refers to the changes that groups and people go through when they come in contact with another culture" (Lipsicas & Makenines, 2010, p. 275). Numerous studies have indicated that acculturation has a significant impact on mental health of minority youth (Baughman, et al., 2014; Lipsicas & Makinen, 2010; Sirin, et al., 2013). Acculturative stress relates to "the potential challenges immigrants face when they negotiate differences between their home and host cultures" (Sirin, et al., 2013, p. 737). Acculturative stress arises from multiple aspects of the acculturation process, such as exposure to the new cultural rules and expectations, facing prejudice and discrimination, and facing challenges to maintain their old cultural roots while adapting to the new culture (Sirin, et al., 2013).

Moreover, youth and their parents may experience conflict because they acculturate at different paces. Intergenerational conflict between culturally traditional parents and acculturated youth has been found to lead to increased suicidality, substance abuse, and behavioural issues (Pumariega, et al., 2005; Lipsicas & Makenines, 2010).

In contrast, some studies show that refugee and immigrant children have lower rates of psychological problems compared to the general population (Kirmayer et al., 2010; Crowley, 2009). The rate of psychotic disorder among immigrant youth is not higher than in native-born children. Research also finds that not all youth who have experienced war and political violence in the pre migration stage have mental health conditions, which could be associated to their strength and resilience (Crowley, 2009; Kirmayer et al., 2010). Current literature proposes that some refugee children will suffer from PTSD, anxiety, and depression; however, others may not and several studies show that in fact refugee children function higher and immigrant children may adjust socially and emotionally better compared to native-born populations (Crowley, 2009; Baughman, et al., 2014). Generally, it has been found that immigrant children and youth present more often with behavioural disorders and identity conflict, and less often with acute psychiatric problems (Pumariega, et al., 2005). According to Pumariega, et al. (2005), "there is no evidence that psychosis related to schizophrenia or bi-polar disorders are more prevalent amongst minority populations than amongst whites" (p. 545).

Baughman et al. (2014) also found no research evidence suggesting that social and emotional disorders were necessarily more dominant among populations of immigrant children. However, if those disorders were manifested, they were in the forms of behavioural deviance and identity conflicts. From the psychodynamic framework, children's problems were explained as a

result of separation and loss experienced during the migration stages and from a psychosocial perspective, the result of disruption and conflict of cultural values and practices.

Mental Health Disorder

A mental health disorder is "the presence of psychological distress; impairment in psychological, social, or occupational functioning; or, any disorder that is associated with an increased risk of suffering death, pain, disability, or loss of freedom" (Crowley, 2009, p. 324). Crowley (2009) refers to Post Traumatic Stress Disorder (PTSD) as being one of the most common variables studied in refugee populations with mental health issues (p. 324).

Refugees and Immigrants

As a result of internal struggles, terrorism, civil war, ethnic cleansing, massacre, and violent and unstable living situations in some countries, we face mass-forced migrations of men, women, and children from their home countries (Crowley, 2009).

Many different terms are used to describe refugee and immigrants (Canadian Council for Refugees, 2010, p.1). This study applies general definitions of refugee and immigrant, whereas a refugee is "a person who is forced to flee from persecution and who is located outside of their home country" (Canadian Council for Refugees, 2010, p.1) and immigrant is defined as "a person who has settled permanently in another country" (Canadian Council for Refugees, 2010, p.1). Immigrants chose to leave their home country for better economic opportunities; however, refugees are forced to flee their home countries due to their traumatic events and cannot return to their home country due to terror of persecution as they may belong to a particular social,

religious, or political group (Crowley, 2009; Barozzino, 2010). Some refugees have experienced persecution, physical and emotional trauma, and forced relocation that would lead to development of psychological disturbance prior to and following resettlement and make their experiences different from immigrants who come voluntarily (Maurray, Schwitzer, & Davidson, 2010; Fantino & Colak, 2010; Whitley & Gould, 2010).

Stages of migration. The refugee experience is commonly divided into three stages: pre migration, migration, and post migration. Refugees escape their home country in the stage of pre-migration, which often involves separation from parents or guardians, social upheaval, chaos, and school disruptions (Kirmayer, et al., 2010; Crowley, 2009). In the post migration phase, the immediate threat of danger is removed, but new stressors will arrive. They face cultural bereavement, which refers to refugees' responses to the loss of their home lands, culture, family, friends, and material possession that is accompanied by feelings of anger, survivor guilt, and ambivalence. In this stage, they are confronting various psycho-social issues such as adjusting to the new culture, language barriers, meeting their basic needs of housing, employment, and health care. This stage is also different for refugee children who are now placed in to a new school system. During this experience, adolescents in particular, encounter discrimination from other students and teachers. Refugee children are often used as cultural liaisons for their parents because of the child's more rapid language learning. This role change and increased rate of acculturation of young refugees can be stressful on them (Crowley, 2009).

Barriers to Treatment for Refugees and Immigrants

Minority youth experience growing inequalities in their access to mental health services (Pumariega, et al., 2005). This is because of the multiple challenges they already face in socioeconomic status and due to lack of culturally competent services that can address their specific mental health needs based on their culture, family, and community (Gushulak, et al., 2011; Pumariega, et al., 2005; Nazzal, Forghany, Geevarughese, Mahmoodi & Wong, 2014).

A language barrier is one issue many immigrants must manage when accessing health services. Studies show that a large percentage of new immigrants are illiterate in both official languages (English and French) in Canada. Health care workers often recognize the linguistic and cultural needs of many immigrant communities in working with new immigrants (Gushulak, et al., 2011; Fantino & Cloak, 2001; Hansson, et al., 2010; Ngo, 2009; BC Partners for Mental Health and Addictions, 2006). Another barrier is cultural differences (Gushulak, et al., 2011; Fantino & Cloak, 2001; Ng, et al., 2007; Hansson, et al., 2010; Ngo, 2009; "BC Partners for Mental Health and Addictions," 2006). Even if health care is accessible to the new immigrants, their understanding of health issues and treatment is different from the western culture. Cultural beliefs can influence new immigrant's understanding of their health issues and selection of treatment (David, 2006; Gushulak et al., 2011; Ng, et al., 2007; Nazzal et al., 2014).

Barriers to accessing health-care services for immigrants also include trust issues or fear of perceived authority figures and educational barriers (Barozzino, 2010; Davis, 2006). Some immigrants may not be able to access treatment due to their illegal status, lack of resources and fear of detection (Flores, 2009). Immigrant and refugee youth are often challenged by complex issues of acculturation including psychological and cognitive issues due to the cultural

adjustment and adaptation. New immigrants often encounter systemic issues such as unemployment, isolation, poverty, internalized racism, physical and mental health challenges, cultural and language barriers, illiteracy, discrimination, and limited civic participation (Ngo, 2009; Hansson et al., 2010; Gushulak, et al., 2011; Fantino & Cloak, 2001; BC Partners for Mental Health and Addictions, 2006; Pollok, et al., 2012). In summary, the compounding major barriers to mental health care for some refugee and immigrant populations are: poor income, an imposed three month wait time to receive access to health insurance in several Canadian provinces, an exclusion of temporary workers, foreign students, visitors, and undocumented migrants from provincial health coverage, the high cost of necessary medications, and transportation to access medical treatment (Hansson, et al., 2010, p. 24). In addition, if refugees or immigrants access services, health care providers may have personal biases or lack knowledge of particular cultural groups and the people they are serving (Barozzino, 2010).

Role of Health Care Providers

Ng et al. (2007) have emphasized the importance of designing culturally appropriate services and programs in health care settings. Flores (2009) indicates that health care providers need to increase their knowledge to better understand the diverse culture of their clients as well as the socio-economic, environmental, and political factors affecting their client's daily life. They need to provide refugee and immigrant children with resources that are relevant and culturally sensitive to better meet their needs (Fantino & Colak, 2001). They need to facilitate a sensitive and informed process for children to integrate into the Canadian society (Fantino & Colak, 2001).

Cooper and Lesser (2011) describe that cross-cultural therapists can play different roles in order to better meet the specific needs of their clients, such as advisor, advocate, consultant, psychotherapist, facilitator, agent of change, and counsellor. Health care providers should also address social needs of the refugee families such as financial, employment, health, welfare, and education services early that can motivate refugee families to be in contact with health care system (Crowley, 2009; Nazzal et al., 2014).

Murray et al. (2010) argue that increased awareness, training, and funding are needed to implement interventions that work collaboratively with refugee clients throughout resettlement. In working with refugee clients, health care providers need to take a holistic approach that recognizes cultural differences and inherent strength and wisdom within the community of refugees (Murray, et al. 2010; Pollok, et al., 2012). An effective approach is applying culturally appropriate interventions that would engage with refugees and would honour their cultural systems and values to promote the process of recovery and resilience (Murray et al., 2010; Davis, 2006; Cooper & Lesser, 2011). Nazzall at al., 2014 also suggest that community-based mental health services, outreach, informal support systems, and collaboration with ethnic and religious groups also appear to be more effective for refugee communities.

Treatment Models

Health care professionals who provide mental health services to refugee clients need to apply therapeutic interventions that are appropriate and effective for their clients (Murray et al., 2010). Most studies show the ranges of interventions such as Psychoanalytic therapies, Cognitive Behavioural Therapy (CBT), anxiety focused, grief focused, and trauma focused therapies being

used frequently in treatment of the minority children and youth (Murray, et al., 2010, p.578). "Individual or group CBT is generally accepted as an effective trauma-informed treatment for refugee children" (Birman, et al., 2005, p. 8). The efficacy of CBT remains controversial, whereas some studies show that it has been recommended for all clients regardless of their racial, cultural, or socioeconomic conditions because it emphasizes structure (Murray et al., 2010; Cooper & Lesser, 2011). Eye Movement Desensitization Reprocessing (EMDR), art and expressive therapy, exposure therapy, and pharmacological therapies are also shown to be effective in treatment of PTSD of refugee populations (Murray et al., 2010; Birman et al., 2005).

Since refugees often depend on their families, family inclusion is very effective in the treatment process of refugee children (Crowley, 2009). Psychoeducational and parenting interventions for mothers are also studied and found to be effective with traumatized refugee children (Birman, et al., 2005, p. 10).

Cooper and Lesser (2011) point out that applying the multicultural relational model, ethnic sensitive framework, anti-oppressive model, strength-based perspective, and/or ethnographic multicultural approach would be more appropriate and more effective in working with refugee and immigrant children and adolescents (p.70-71). The authors also highlight that effective multicultural practice depends mostly on the therapist's cultural and racial sensitivity, therapeutic goals that considers the client's level of acculturation, selection of modality that fit client's needs, and the therapist's awareness of the issues of value, power, and privilege (p.72). Murray et al. (2010) state "there is a need for additional well designed, empirically validated, and culturally appropriate therapeutic interventions that also examines carefully the specific

therapeutic process associated with increasing resettled refugee mental health and well-being" (p. 581).

Controversies and Implications of the Diagnosis

Crowley (2009) indicates "the concept of labeling child and adolescent refugees with psychiatric diagnoses such as PTSD or depression remain controversial and has been criticized as inappropriate labeling that fails to consider the distress experienced and adversities suffered (p. 324)". The DSM-IV reflected mainstream western culture that saw mental illness as a medical condition and does not reflect on other cultures that are more spiritual and view health, mind, and spirit as intertwined (Dalton, 2012; Belfer, 2008; Gojer & Ellis, 2014)."Different cultures see mental health differently" and their cultural or spiritual views may affect treatment and recovery (Dalton, 2012 p. 50). According to Belfer (2008) "the DSM-IV diagnosis classifications for children and adolescents are wrongfully inadequate and of limited applicability in global epidemiological studies" (p. 225). Whereas Stanley, Huey, & Polo (2008) noted, "the simple act of defining, labeling, or classifying ethnic minorities is fraught with ambiguity. Race, ethnicity, and culture are complex and fluid constructs, and thus not always agreeable to categorization without the loss of crucial information (p. 296)."

Gojer and Elise (2014) explain that medical model sees mental illness as a biological condition or a disease and assumes that diseases are universal. However, the social constructionist approach to illness is about the social meaning of the condition and emphasizes on how the meaning and experience of illness is shaped by cultural and social systems. For example, PTSD that is defined by westernized model as a diagnostic category may have less

applicability to refugees from non-western cultures. Trauma as a language has become universalized and normalized by the mental health experts. Also, the knowledge and experiences of trauma has been reproduced into defined and classified diagnostic categories which have become legitimized through the language of mental health and the Diagnostic and Statistical Manual (DSM-V) (Gojer and Elise, 2014, p. 6-7).

The medical model fails to consider the contribution of the socio-political circumstances to the traumatic event and ignores the cultural perspective of mental health and recovery. Therefore, PTSD is not a biologically predetermined disorder which the medical model labels as a disease (Gojer & Elise, 2014). Instead, "PTSD must be viewed through the broader perspective of social constructionism which highlights that this diagnostic category was created by scientists and is flawed by the self-serving hegemony of psychiatry and psychology" (Gojer & Elise, 2014, p.7). However, Crowley (2009) supports that diagnosis and labeling of certain conditions may be the only effective way of receiving appropriate resources to ensure children who have had trauma are properly evaluated and referred to proper treatment resources if need be.

Research Gaps and Limitations

Crowley (2009) points out that there are many gaps in the literature concerning mental health issues of refugee children. Most studies indicate more research is needed in both the immediate and long term resettlement periods in order to fully comprehend the difficulty of refugee children and adolescents and to improve the quality of primary care for them (Crowley, 2009; Gushulak, et al., 2011). Stanley et al. (2008) states, "Unfortunately, cultural-responsive practice is rarely described in significant details in the youth treatment literature" (p. 294).

However, Crowley (2009) and Davis (2006) highlight that screening tools, assessment and treatment need to be culturally safe and culturally sensitive in order to respond effectively to the diverse needs of the minority clients.

In many studies, diverse immigrant and refugee groups are often treated as one group or they are grouped by major geographic region such as Asian, Spanish, or African. This categorization of groups may compromise the development of equitable services at a local level as there are significant cultural and language differences in people from the same continent or the same country. Studies fail to differentiate ethnic minorities from immigrants and refugees, limiting assessment of specific risk factors associated with immigration (Hansson, et al., 2010).

Furthermore, very limited studies talk about the importance of the multicultural relational model, ethnic sensitive framework, anti-oppressive model, strength-based perspective, or an ethnographic multicultural approach that would be more appropriate and more effective in working with refugee and immigrant children and adolescents (Cooper & Lesser, 2011). There are few Canadian research initiatives at a policy or service level that aim to improve the quality of mental health care, especially for immigrant and refugee populations (Hansson, et al., 2010).

There are also few studies that address the challenges that mental health care workers confront when working with refugee and immigrant children and youth. There is limited research of the systemic issues that refugees face in the host country such as racism, difficulties accessing resources and unsympathetic political and public reactions to their existence (Moodley & Ocampo, 2014). The post migration problems such as fear and anxiety of the refugees over deportation, their struggles with the legal process, separation from family, loneliness, poverty,

and discrimination have been neglected in the research (Moodley & Ocampo, 2014; Kinnon, 1999; Crowley, 2009; & Pollock, et al., 2012).

Theoretical Framework

Pollock et al. (2012) illustrate that the current research does not recognize discrimination as a main element of health care services, in that discrimination effects newcomer's health, their health care experiences, and service use. Young people who are new to Canada are more likely to experience discrimination, marginalization and harsher stigmas (BC Partners for Mental Health and Addictions, 2006; Ngo, 2009).

As Cooper and Lesser (2011) relate the impact of racism, other forms of oppression, social injustice, and other human rights violations need to be addressed in multicultural clinical practice and in working with racial and minority clients. Social workers need to assess the effects of racism, prejudice, and sociocultural factors on the life of the clients (Cooper & Lesser, 2011). Davis (2006) mentions that the Mental Health Commission of Canada in its 2009 framework highlighted that mental health policies and treatments need to be culturally competent, and need to address experiences of racism and migration history. Although some progress has been made, there remain considerable barriers that prevent people from receiving appropriate treatment.

Ugiagbe and Eweka (2014) also describe that in society, oppression operates on three levels at all times: on a personal, cultural, and structural level. The authors explain that at the personal level, oppression contains the thoughts, attitudes, and behaviours that portray a negative pre-judgment of a particular minor social group and it is based on stereotypes and may be evident or implicit. Oppression at the cultural level portrays the dominant culture as the norm

and forces the subordinate group to adapt to it, which can lead to ethnocentrism and cultural imperialism. Structural oppression refers to the ways that social institutions, laws, policies, social processes and practices, and economic and political systems all work together to favour the dominant group over the subordinate groups.

According to Baines (2011) "Anti-oppressive practice (AOP) is one of the main forms of social justice oriented social work theory and practice" (p. 4). The author points out that this approach would recognize the complexity of today's social problems and underlying structural factors that create oppression and the emergent need for major restructuring of all levels of society. He argues, in our society, access to resources, power, and endorsing identity are not distributed equally because of the issues of class, race, gender, and ability, etc. AOP tries to see the client's problems from a structural perspective meaning that their problems are due to limited choices and the interplay of social, political, cultural, and economic factors that clients generally have little awareness or control over.

Sarang et al. (2009) argue that mental health services treatment models should have anti-racist approach as racism affects the physical health and mental health of individuals and communities. Individual and systemic racism can create barriers to the quality of care and access to mental health services. The culturally inappropriate intervention methods, inappropriate use of interpreters, lack of cultural knowledge, and the biased attitude of mental health providers are some of these barriers that prevent racialized clients from seeking help.

Sarang et al. (2009), Cooper and Lesser (2011), Davis (2006), Crowley (2009), and Ng et al. (2007) have all highlighted the importance of designing services and programs that are

culturally appropriate for treatment of ethnic minority clients to improve the service delivery. "Lack of racially, culturally and linguistically appropriate health care information create severe disparities in the access to health care services" (Ontario Council of Agencies Serving Immigrants (OCASI), 2005, p. 3).

However, an anti-oppressive analysis can explore the underlying sources of ongoing trauma, racism, and the required organizational and structural changes necessary in the mental health system to address cultural and linguistic disparities. Anti-oppression frameworks recognize that discrimination against racialized people is not only based on their race, but may also be based on their religion, language, ethnicity, class, gender, sexual orientation, disabilities, age, country of origin and citizenship status (Sarang et al., 2009). According to Sarang et al. "truly holistic care must respond to the intersectionality of all forms of oppression" (p.3).

In fact, racism and mental health cannot be addressed separately as they are deeply entwined. By separating racism and mental health, we will be limiting the effectiveness of services and supports. AOP must be integrated into all areas of recovery, including treatment, case management, planning, and outreach. AOP can help the clinicians to use client's oppressive experiences as a first step to discuss the impact of those experiences on their behaviour and ability that can help them heal and recover (Sarang et al., 2009).

The impact of racism should be integrated into a methodological and analytical approach towards the study of the mental health of refugees because on a macro level, it would influence the policies around allocation of resources and at the service and treatment level would affect the direct interaction between health care providers and their clients (Moodley & Ocampo, 2014). In

the federal government, less funding is allocated for services for immigrant youth and there is a lack of funding priority on the "part of citizenship and immigration Canada for immigrant children and youth" (Ngo, 2009, p. 89).

The health and social care systems have shifted towards a managerial enterprise that is rooted in an ideological view that sees individuals as being responsible for their own problems and solutions, ignoring structural inequalities, and oppression (Gregory & Holloway, 2005). The language of care has shifted to the language of risk management and consumerism that is concerned with efficiency and accountability, while neglecting people and ignoring long term systemic and preventative solutions (Gregory & Holloway, 2005). Managerialism and privatization have resulted in the elimination and/or privatization of programs for minority populations (Baines, 2011). Immigrants, racialized communities, and refugees who are socio-economically disadvantaged may not be able to afford to pay for privatized health care. Moving from publically funded specialized health care programs to elimination and privatization would make refugees much more vulnerable (Ontario Council of Agencies Serving Immigrants (OCASI), 2005). The combination of managerialism and neoliberalism has resulted in poverty and asocial injustice (Baines, 2011).

Methodology

This study explored the appropriateness of the various assessments and treatment interventions for refugee and immigrant children and youth who were experiencing mental health issues from a clinician's perspective. The study used an exploratory, qualitative, cross-sectional, inductive research design. The sample population included five interdisciplinary front line

clinicians of two Child Youth Mental Health (CYMH) community centres located in Burnaby, BC. A criterion sampling method was employed to recruit the participants.

Following approval of Research Ethics at the University of the Fraser Valley (UFV) and ethics approval from Applied Practice Research and Learning at the Ministry of Children and Family Development (MCFD), the primary investigator (PI) was granted two potential research sponsors, MCFD Community Service Managers. The Community Service Manager sponsor from the Tri-Cities Office assigned a team leader at CYMH, Port-Moody Centre to help facilitate the project. The team leader sent invitations and an explanation of the research to potential participants at three Mental Health Centres and requested that potential participants contact the PI directly. Five participants from two of the Child and Youth Mental Health Centres in Burnaby, BC volunteered to participate in the research. No clinicians volunteered to participate in the study from the Port-Moody Mental Health Centre, BC. Each of the potential research participants received a letter of informed consent and the survey/interview questions prior to the interviews. Participants contacted the PI to schedule an interview at a time and place convenient to them. The PI administered five semi-structured face-to-face interviews in August of 2015. The participants gave informed consent to allow the researcher to take notes and audio-record the sessions.

The interview and survey questions were designed by the PI to gather participants' perspectives and experiences around culturally appropriate assessment and treatment interventions to refugee and immigrant children and youth with mental health issues. The interview consisted of nine open ended questions and the survey was composed of 14 closed-ended questions following two open ended questions. The PI used various questions in the

survey such as multiple choices, Likert scaling, and interval scale questions. By using true and false (T/F) questions, the PI forced participants to make a decision about their answers; they were also useful to test participant's misconceptions about cultural competency. However, the same T/F questions were asked again in the interview and participants were given an opportunity to elaborate on their answers and provide examples. The open-ended questions in the interview provided opportunity for participants to provide various responses and reflections on specific area. The terms "minority" and "immigrant and refugee" were often used interchangeably in the survey/interview questions. However, the PI was only targeting immigrant and refugee children and youth for this research.

The survey/interview questions were reviewed by UFV Research Ethics Board and revisions were suggested. MCFD also reviewed the interview/survey questions; however, no revision was recommended. The interviews were conducted at the participants' offices and were approximately 30-80 minutes in duration. During the sessions the PI provided clarification regarding the questions, reviewed the participants' answers, and sought clarification as needed in order to increase the validity and credibility of the data. Basic demographic data such as participants' ethnicity, education, years of experience, and language spoken were gathered through the survey questions to enable a description of the sample of participants. Data were stored in a password protected file on a personal computer.

A transcript of each interview was produced from audio-recordings and the written interview notes. Once the interviews were transcribed, the PI reviewed each transcript a few times to particularly highlight the key points and to identify major concepts. The data were analyzed for similarities, comparisons, and intersecting themes, patterns, and concepts. Informed

by the theoretical framework developed during this research, the themes were further grouped together. The following six themes emerged from data analysis, DSM-5: implications for minority children and youth, cross-cultural training and education, intervention models, program development, barriers to accessing treatment, and increasing cultural awareness.

Ethical Consideration

Full consent was obtained from the participants prior to the study, which disclosed the nature of the study, risks, benefits, and alternatives. While collecting the data, no participants raised any concerns regarding the anonymity of their responses or emotional distress. All participants were advised that they could decline to respond to any questions and could stop the interview at any time.

This study solicited participants' beliefs and experiences about professional decisions and interventions. The clinician's expertise was respected and neither challenged nor questioned.

Throughout the interview, participants were free to ask questions and at the end of each interview they were provided an opportunity to share concerns or questions. One of the participants continued when the interview questions were completed to share some personal stories related to the research subject. All participants expressed interest in knowing about the results of the interview. All research participants were offered a copy of the final research report. There was no identified harm or risk to the participants during the interview interaction. The researcher was aware of personal and professional biases that may have interfered with this research. The researcher also attempted to maintain the highest level of objectivity in discussion and analyses throughout the research.

Findings

The five female participants in study included one clinical social worker, one child care counsellor, two marriage and family therapists, and one early childhood development therapist. The participants were from different disciplines and provided various assessments and treatment interventions to refugee and immigrant children and youth and their families. The participants' years of professional experiences ranged from 11 to 27. Three participants self-identified as Caucasian, and two self-identified as members of ethnic minorities. Four of the participants spoke languages other than English. Participants reported having caseloads that included 25-75% of refugee and immigrant children and youth. All the participants expressed a great passion in working with refugee and immigrant children and youth, especially the ones who were immigrants themselves. They all felt fairly confident helping the immigrant and refugee clients and expressed that their jobs are rewarding and they receive a lot of joy and satisfaction serving refugee and immigrant population.

The next section provides an analysis of data that were collected through the survey and interview questions. The data analysis resulted in the identification of the six key thematic areas discussed below. It will reveal different perspectives, beliefs, and practices of the individual clinicians.

DSM-5: Implication for Minority Children and Youth

When asked, three participants spoke about the DSM-5 as having inappropriate diagnostic classification for minority children and youth. One of them stated,

> We can't only treat children and youth if they fit the DSM-IV or 5 classification or criteria, but management and some clinicians have a very narrow way of looking at issues. Immigrant and refugee clients have multi-layered problems. We need to have a holistic approach. The whole family has problems. They only look at the individuals, which in reality is only one part.

Two participants stated that DSM-5 is in fact an appropriate diagnostic classification for ethnic minorities. Three people believe culturally screening tools and assessment are essential for treatment of minority children and youth with mental health issues. They mentioned that we need to incorporate cultural, spiritual, religious factors into psycho-social assessment and treatment methods should also reflect the culture- specific values and needs of clients. One participant mentioned that we could provide multilingual services to clients. However, two people stated that it is not essential for the screening tools and assessments to be culturally sensitive.

Cross-cultural Training and Education

All participants highlighted the importance of diversity education and training for staff. Three people emphasized that although the Ministry of Child and Family Development has been talking about providing more training to staff and there has been a "big push" for this; however, limited training has been provided to staff. Three people shared they had no training for cross-cultural mental health in the last five years. "There has been less training for cultural appropriate treatment, we need more training." Two people stated that they had some training in the last five years.

Two participants spoke of their programs as being inviting to ethnic minority clients by providing them with services that fit their specific needs such as multilingual services and interpretation services when needed. One participant stated that:

> We are very welcoming to any family. We have multicultural staff. We use non-verbal language or show them in action when there is a language barrier. We change our language and adapt it to their level of understanding. We make it simple for them by using lots of gestures and examples. Burnaby is very diverse with more diverse resources for the clients.

Two participants stated that their programs are inviting to younger children; but not for youth. "We can be more inviting, but some staff are not very flexible, they are reluctant sometimes to see youth with complicated issues, which could be due to lack of training, being understaffed, and under resourced. Another participant stated, "…depends on the team leaders and individual clinician and their personal attitude. Some team leaders or clinicians have rigid boundaries." One person remarked, "Not sure we are inviting or not. Maybe yes, maybe not. We can do a better job by working in collaboration with community resources, cultural or faith communities or clergymen." One participant emphasized that Child and Youth Mental Health services need to work in collaboration with other agencies such as day care, pre-school and schools, and public health to be able to make it more inviting for the immigrant and refugee clients. She mentioned more planning and collaboration with other agencies in the community is needed.

One participant stated, “Informal assessment is also very important. Sometimes basic relationship building and just being there with the clients and learning about their culture, religion, and showing interest in it, willing to take the time to get to know their point of views and values and what is important to them.”

Cultural humility. Four participants were consistent in their responses regarding cultural humility and they all believe that it is the foundation of therapy. Below definition of cultural humility is a compilation of participants’ responses.

> Cultural humility is knowing no matter how much you know, you don’t know… is being humble. If you’re not humble, they can sense it. If they know you are real, they can make a better relationship. Cultural humility means accepting where the clients are and adapting into their situation. It means I don’t know everything about client’s culture and I have to ask questions, check out my own assumptions. Within the same culture there are differences, we need to check those differences.

An interesting perception was shared by one of the participants, “Try to make issues personal and human not cultural. Like Asian parents are strict, but German and Irish parents are the same. Culture can be used as a scapegoat of justification of certain behaviors. I try to focus on individuality, personal and human experience rather than culture. Even within the same culture, there might be differences.”

Intervention Models

All participants believe that cultural beliefs of the immigrant and refugee children and youth influence their understanding of mental health issues and the selection of treatment. Four participants shared that they apply various model of treatments with their clients based on their mental health diagnosis. The various models identified were CBT (for older children with depression and anxiety), trauma focused therapy for children and youth who have PTSD, family approaches, play therapy and art therapy for younger children, as well as the community building model, outreach, and psycho-education. One participant remarked, "Through expressive arts, children will express their trauma, strengths, personalities, and humour. We need to also focus on their strength and resilience, not just their trauma." One participant mentioned she applies "Refugee CBT" or "trauma focused CBT" with refugee children.

Another participant stated, "I use any model that can bring the child and parents together either for relationship or developmental response. Refugee parents sometimes are coming from a harsher parenting, so helping them to transition to a more responsive parenting can be challenging. They see me as the expert and rely on me solely to help their kids."

One participant stated,

> The treatment I use depends on what the client brings to the meeting, but I don't change my model of treatment for immigrants or refugees, I use the same model for ethnic minority clients as I do with the fifth Canadian Caucasian generations. We cannot be too rigid about developing certain models of the treatment for certain cultures…although, I know using a narrative therapy works better for Aboriginal populations, but being too

> rigid is not effective. Starting to develop a special model, special approach for refugees and minorities is bad practice because we're making assumptions. They may need special consideration, but the same consideration should be given to the mainstream culture.

All participants stated that they play different roles to support and to meet clients' basic needs including the roles of therapist, coordinator, social worker, broker, teacher, liaison, advocate, coach, and case manager. "I do whatever it takes to help them get better, I will cook with parents. I will use non-verbal communications and role play when there is a language barrier. I will do outreach if they have no transportations, I will get on the bus with them and take them to resources they need for their treatment."

Program Development

Three participants shared that for developing appropriate and effective intervention models, Child and Youth Mental Health services need to consider a few factors. Staff need to expand their knowledge about the cultural diversity of their clients. They need to adapt to their needs and they also need to develop curriculum and process that would fit their client's specific cultural needs. They need to work collaboratively with families and community agencies. They need to be mindful of the impact of poverty and systemic issues on their client's lives. One participant expressed,

> We're getting more refugee and immigrants moving to Burnaby and Tri-Cities because of being low income, but we don't have enough resources for them. We have good connections with Aboriginal resources for Aboriginal kids, but not for other minority

> children we see. If we work collaboratively with community resources is good practice. We are just scratching the surface with developing appropriate models for minorities.

One participant stated, “We need to modify traditional therapies to adapt to the needs of the clients. The main therapy is really understanding them. We need to use a holistic approach.”

One person said, “We don’t have to come up with a new therapy, you have to adapt to the existing ones, even within same culture, you may have differences.” Two people mentioned that some clients identify with their culture, while some clients reject their culture. Whereas, two participants noted that due to providing short term treatment, they did not get to know their clients and their problems. “It takes years sometimes to get the parents to engage with us.”

Increasing Cultural Awareness

All participants agree that cultural competency is essential to good clinical practice. They all mentioned that they use several ways to increase their knowledge of the culture of their clients such as, the client’s experiences, traveling, government websites, and other resources. They also stated that they talk to children and youth, their parents (legal guardians, foster parents) siblings, relatives, friends, school, referral sources, and other agencies to gather collateral information. Some clinicians speak the same language as their clients, but when there were language barriers they sought the support of other staff at the agency, parents, family or friends of the children and youth for interpretation. Two participants mentioned using professional interpreters as well.

Barriers to Accessing Treatment

All participants spoke about the unmet basic needs of the refugee and immigrant families as the main barrier to accessing treatment. They all expressed ethnic minority families have complex issues, compared to the mainstream populations. They have social and financial issues such as poverty, lack of proper housing, unemployment or under-employment, lack of transportation, and lack of day care. As one participant put it, "The whole family has issues, mental health is the whole family." They all emphasized that the unmet basic needs of the family has a significant impact on their mental health and would delay their mental health treatment. "Some clients are pushed to get help way too early, they have other issues to work on; their basic needs are not met yet. They live in a small place, we take them food, clothes and toys for the kids; they are poor."

Two participants emphasized that Child and Youth mental health being under MCFD is also a barrier to treatment for two reasons. First, because there is a misconception about MCFD and some parents think their children will be taken away if they know they have problems and secondly, because most refugees have had traumatic experiences with government agencies in their home country and this issue would prevent them from seeking help.

Language and cultural barriers and stigma attached to mental health were also identified by all participants as major barriers. "Some families perceive receiving help as a taboo. They don't want to be called crazy". "Privacy and confidentiality are very important in some cultures. They do not seek help because they have a fear of their privacy being invaded. One participant

mentioned, “We have to identify our program as “early childhood” not “mental health” in order to help them get the help they need.”

Four participants emphasized that in some cultures, especially in families who come from poor countries, parents rely on the clinicians entirely to help their children and fix their problems; however, the parents themselves need to be in the driver’s seat and in charge of their own kid’s treatment and recovery and this can be also a barrier. Sometimes, parents may not be in agreement about their child’s treatment, which prevents them from getting the proper treatment for their children.

One person mentioned that mental health referrals typically come from the school or other community resources, and if the immigrant and refugee children and youth are not connected with these public resources, they do not receive mental health support. Four participants also spoke of clinician’s biases, rigid personal attitudes, and cultural clashes as barriers to treatment.

Discussion

This research explored the appropriateness of assessment and treatment intervention for refugee and immigrant children and youth with mental health issues from the clinician’s perspectives. The terms “minority” and “immigrant and refugee” were often used interchangeably throughout this study; however, the focus was on immigrant and refugee children and youth. The research participants discussed their current theoretical beliefs, practices, and policy implications. Most themes that emerged in the interviews were consistent with the themes within the literature. A few themes were also identified by the participants that were

inconsistent. The research participants believed building rapport with refugee and immigrant clients and having cultural humility, are the foundations of any therapeutic relationship, and have a significant impact on clients' mental health treatment.

The findings were congruent with other research in terms of the influence of culture on the understanding of mental illness and treatment selection. Providers were also certain that cultural beliefs of the clients would influence their understanding of their mental health diagnosis and selection of the treatment. However, one result that emerged from the findings was the implication of utilizing the DSM-5 for treatment with ethnic minority children and youth, requirement of culturally appropriate assessment tools, and the development of appropriate resources were partially consistent with the research literature. In contrast, some health care providers believe that the DSM-5 is an adequate diagnostic tool for psychiatric diagnosis and treatment recommendations for refugee and immigrant children and adolescents. They also believe that screening tools and treatment models do not need to be culturally sensitive; therefore, there is no relationship between the use of culturally appropriate screening tools, treatment models, and the effectiveness of treatment for minority refugee and immigrant clients.

The findings support participants' comments there is a substantial need for more education and training for clinicians around cultural diversity and cross-cultural mental health. These comments were consistent with the previous research that highlights the importance of training staff to improve cultural awareness and competence (Murray et al. 2010). Furthermore, the participants emphasized the importance of engaging with families and working collaboratively with other community resources. Likewise, if providers worked collaboratively with faith communities, then clinicians can play an important role in supporting the ethnic

minority clients, providing spiritual, social, and financial support. The effectiveness of collaboration with religious groups to support refugees was also highlighted in the literature (Nazzal, et al., 2014).

The results are congruent with past studies that provide an understanding of the complexity of the issues refugee and immigrant children and youth experience (Gushulak, et al., 2011; Pumariega, et al., 2005). Throughout this research, the participants reported a correlation between socio-economic status and other identified life stressors of refugee and immigrant clients and their mental health. Some of the barriers identified in this study to immigrant and refugee children's mental, emotional, and developmental heath were, poverty; parents' unemployment or under-employment; and lack of food, clothes, and toys. Poverty and unequal allocation of resources to refugee and immigrant children and youth discussed by the participants were consistent with the literature that supports the significant impact of the structural oppression on the physical and mental health of immigrant and refugee children and youth (Moodley & Ocampo, 2014; Ngo, 2009; Sarang et al., 2009). Participants also emphasized the importance of assessing the client's overall psycho-social functioning by applying a holistic approach. The literature and the research support that client's basic needs must be met before their mental health issues are addressed. It was clear that clinicians adapted to the different roles to be effective in helping clients overcome systemic barriers and challenges.

The participants also reflected on some of the barriers to accessing treatments, such as language, culture, family, community, and systemic issues. One systemic barrier stressed by the research participants, is about CYMH services being under MCFD. The literature talks about the refugee client's fear of authority and lack of trust in government agencies due to their past

traumatic issues; however, it does not identify CYMH being under MCFD as one of the barriers to accessing treatment. Participants also emphasized that their programs should be more inviting and sensitive to the needs of the immigrant and refugee children and youth and highlighted clinician's personal attitude and biases and systemic issues including lack of staff training and resources as key barriers. The existing research also supports the significant importance of impact of racism, and other forms of oppression such as personal, cultural, and systemic on quality of care for refugee and immigrant children and youth (Lesser & Cooper, 2011).

Recommendations and Future Research

Culture has a significant impact on the understanding of mental health issues, diagnosis, and treatment. Therefore, health care providers need to receive on-going diversity training and incorporate cultural factors into refugee and immigrant children and youth psychosocial assessments and treatment model approaches. Mental health agencies need to promote cultural diversity in the organization by improving the organizational culture, structures, and policies that reduce structural barriers for clients. This can be accomplished by providing multicultural, multilingual programs, and hiring and promoting diverse staff who can support the identified needs of the refugee and immigrant children and youth.

Policy makers, management, and health care providers need to include refugee and immigrant youth and their family in research, planning, implementation, and evaluation of services. They are the experts of their culture and can identify services that best meet their needs. Refugee and immigrant populations have strengths and resiliency that can be recognized and

integrated into new service plans. Their inclusion and participation can also promote equality and social justice.

Health care providers need to work collaboratively with other community agencies to provide a holistic approach and to offer efficient models of service delivery. Collaboration with other agencies in the community such as Immigrant Settlement agencies, multicultural programs, schools, child protection, religious organizations, etc. will help develop partnership that would support refugee and immigrant children and youth to meet their multi-faceted needs.

Government needs to improve provincial policies to ensure providing equitable resources and quality services to refugee and immigrant children and youth. Provincial government needs to change policies or programs to meet the diverse complex needs of refugee and immigrant children and youth. Three months wait time to receive provincial health insurance for immigrants should be removed to improve immigrants' access to timely mental health assessment and treatment. For example, provincial government can improve refugee's access to mental health services by reducing lengthy waitlists, more accessible locations, and timely services. Timely and affordable access to services should be considered as strategic goals or priorities. As participants noted transportation costs can also reduce access to and utilization of health care services in the Burnaby area; therefore, providing more outreach programs and allocating more funds for transportation can also improve accessibility to services for poor and low income refugee and immigrants.

In order to better understand the mental health issues of refugee and immigrant children and youth and to assess the appropriateness of mental health assessment and treatments, more in-

depth local studies are needed that focus on the post migration stage when refugees resettle in the Canadian society. Planning appropriate care for minority population would be achieved by assessing the diversity of the local communities, the needs of mental health services, and the resources available for minority children and youth. Engaging local minority population groups and networks of community based services in the assessment and planning process can increase our knowledge about needs of the community, services that are available, and problems accessing services and can also result in improvement of quality services.

Limitations

Due to small sample size and targeting only two of the mental health agencies in the lower mainland, the results of this study cannot be generalized to all clinicians who serve refugee and immigrant children and youth. The data may have been richer if it had included a larger sample from a wider geographical region. The study was constricted due to MCFD's policy that the researcher was not allowed to directly recruit participants, there was limited recruitment time, and participant's availability. All the participants volunteered, which means it was a self-selected group; thus, the clinicians who were willing to share their experiences and beliefs of serving immigrant and refugee clients. The research participants had various educational and clinical training and several were not academically trained as a clinician. Only one social worker participated in this research; therefore, interviewing one social worker was not simply enough to provide a representative sample of the views of all social workers.

This study did not include refugee and immigrant children and youth with mental health issues due to the ethical considerations of this vulnerable population. The project concentrated on

the views of professionals providing direct services to immigrant and refugee children and youth and did not determine the quality or effectiveness of services. The research results would have been richer if the voices of the children and youth themselves were included. Although, some participants identified as minority immigrants, and shared their personal perspectives.

As the primary researcher my analysis has been influenced by the fact that I am an ethnic minority and work as a mental health clinician who provides services to an adult refugee and immigrant population; therefore, I share some professional beliefs and experiences with the sample participants and have some shared personal experiences with the immigrant and refugee clients. The reliability of the results may have been improved by involving a second reviewer in the analysis. In conclusion, my own biases and presumptions may have affected the results of this study.

This study did not reflect all services, assessments, or evaluations provided to refugee and immigrant children and youth. Also, the interview/survey questions may have been leading, biased, and or double barrelled. Interview transcripts, data analysis, and merging themes were not reviewed by peers that could have provided additional insights into themes and would have reduced bias.

Conclusion

The clinicians in this study had insight and knowledge of the significance of culturally appropriate services that could address the specific needs of refugee and immigrant clients. It was evident that the specific needs of refugee and immigrant children and youth were not entirely acknowledged and met within the structural context of Child and Youth mental health

services. Health-care providers should focus on empowering individuals and their families and consider the structural causes of individual problems, social injustice, and sources of oppression that have significant impacts on their health. There are health care providers who have prejudice against refugee and immigrant children and youth they serve, there is a lack of resources, and oppressive policies that indeed prevent the immigrants and refugees from receiving effective mental health treatment. Consequently, these barriers also increase risks to the physical and developmental functioning of refugee and immigrant children and youth. Health-care providers, management, and policy makers need to consider the complex issues that refugee and immigrant children and youth face and what their specific needs are when implementing services. These research findings contribute to a deeper understanding of the relationship between culturally appropriate treatment, recovery, and policy changes needed at the systems' level that contribute to the well-being of refugee and immigrant children and youth, and the community.

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Appendix A

Ethics Approval

UNIVERSITY OF THE FRASER VALLEY

Certificate of Human Research Ethics Board Approval - Amendment

Contact Person	Department	Protocol
Beheshteh Ahani-Masooleh	Social Work	750S-15
Co-investigator(s) Leah Douglas; Margaret Coombes		
Title of Project To explore the appropriateness of the assessments and treatment interventions for refugee and immigrant children and youth with mental health issues from clinician's perspective		
Sponsoring/Funding Agency N/A		
Institution(s) where research will be carried out University of the Fraser Valley; Child Youth Mental Health agencies in Tri-Cites and Burnaby		

Review Date:	Amendment Date:	Original Approval Date:	Approval Term:
07-Apr-15	06-Apr-15	12-Mar-15	12-Mar-15 - 11-Mar-16

Certification:

The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.

[redacted]

Andrea Hughes, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

Appendix B

Participant Invitation

Behi Ahani-Masooleh
School of Social Work and Human Resources
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8
[redacted]

INVITATION TO PARTICIPATE IN A RESEARCH

Do mental health clinicians provide immigrant and refugee children and youth with appropriate assessment and interventions based on their specific needs?

Dear Potential Participant:

I am Behi Ahani-Masooleh, an MSW student at UFV. I am conducting a research study on the appropriateness of assessment and intervention methods in treatment of refugee and immigrant children and youth with mental health issues. I am inviting you to be part of this research as your perspectives, experiences and feedback as front line clinicians offering direct services to ethnic minority children would be very valuable to this research study.

Your participation is absolutely voluntary and if you choose to participate, you will have the option to withdraw at any time without giving a reason. Before you decide, you can talk to anyone you feel comfortable with about the research.

The research is being conducted as part of the Master of Social Work program at the University of the Fraser Valley. By conducting this research, I am hoping that your perspectives and experiences will help us make sure our resources are meeting cultural needs of the clients and that services have a positive impact. We want to hear more about your wishes for multicultural

services. I am further hoping that through this study, we will assess the challenges and barriers that prevent clients from receiving appropriate services and good quality of care.

If you participate in this project, you will be asked to answer to the survey questionnaire or have a face-to-face or phone interview, which would be decided based on your preference and convenience. Answering to the survey questionnaire will be approximately 30 min. long and the interview would be roughly about 1-2 hrs. The survey questions will be provided to you via email and the interview can be done at your work site or at a more convenient place i.e. coffee shop. The interviews will be audio recorded. You have the option of withdrawing at any point during the interview process and your name or other identifying information will not be used.

Your participation in the study will remain confidential and will not be shared with anyone. Data that is collected in the study will not reveal any identifying information about subjects involved. Prior to participating in the study, you will be provided with a consent form outlining the study. You are encouraged to ask questions before consenting to participate.

The research study, including its purpose and methodology is approved by the Research Ethics Boards at the University of the Fraser Valley and MCFD. If you have any questions or require further information about this study before or during participation, you can contact me (Behi Ahani-Masooleh) at the University of the Fraser Valley at [redacted]. If you have any ethical concerns about this research study, contact Adrienne Chan, AVP of Research, Engagement, and Graduate Studies at UFV, [redacted] or [redacted] . This ethics of this project have been reviewed and approved by the UFV Human Research Ethics Board.

I invite you to contact me if you would like to learn more about this study.

Beheshteh (Behi) Ahani-Masooleh, BSW, RSW, MSW student

Appendix C

Consent Form

Behi Ahani-Masooleh
School of Social Work and Human Resources
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8
[redacted]

Feb 18, 2015

Appropriateness of Assessment and Treatment Interventions Offered to Immigrant and Refugee Children and Youth with Mental Health Issues

Letter of Informed Consent

Introduction

I am Behi Ahani-Masooleh, an MSW student at UFV. I am conducting a research study on the appropriateness of assessment and intervention methods in treatment of refugee and immigrant children and youth with mental health issues. I am inviting you to be part of this research as your perspectives, experiences and feedback as front line clinicians offering direct services to ethnic minority children would be very valuable to this research study.

Your participation is absolutely voluntary. I f you agree to participate, you will be asked to sign this form. Even if you decide to be part of this research by signing this form, you can withdraw anytime you wish during this study. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form will explain about the purpose of this research and will provide you with more information, which will help you to decide about your participation.

Purpose/Objectives of the Study

Minority populations have been growing in the Lower Mainland and Fraser Valley in the last 20 years. Most immigrant and refugee children and youth suffer from trauma, many losses, and other mental health issues due to the hardship they experienced in their home country and through the migration process. It is crucial for the minority children to be provided with treatments that are appropriate to their cultural and specific needs. By conducting this research, I am hoping to assess the appropriateness of the assessments and treatment interventions offered to the minority children. My hope is that your perspectives and experiences will help us make sure our resources are meeting cultural needs of the clients and that services have a positive impact. We want to hear more about your wishes for multicultural services. I am further hoping that through this study, we will assess the challenges and barriers that prevent clients from receiving appropriate services and good quality of care.

Procedures involved in the Research

If you participate in this project, you will be asked to answer to the survey questionnaire or have a face-to-face or phone interview, which would be decided based on your preference and convenience. Answering to the survey questionnaire will be approximately 30 min. long and the interview would be roughly about 1-2 hrs. The survey questions will be provided to you via email and the interview can be done at your work site or at a more convenient place i.e. coffee shop. The interviews will be audio recorded. You have the option of withdrawing at any point during the interview process and your name or other identifying information will not be used.

Potential Harms, Risks or Discomforts to Participants

It is unlikely that there will be any harm or risk associated with this study. However, you may feel uncomfortable answering questions that can be based on your personal perceptions, so please note that you are not obligated to answer questions that may cause any discomfort for you.

Potential Benefits

This study will benefit you, your clients, and your community. By offering services to the minority children and youth that can meet their specific needs, we can make it more inviting for them to seek help that would lead to early assessments of their mental health issues, early prevention, early treatment, and faster recovery. I am hoping that my research would help mental health service providers to look at how their programs are structured and delivered with respect to potential clients from minority groups. Through this study, we can assess any

barriers that can interfere with meeting the client's cultural needs. This study can also help the agency develop more training for the staff and make changes to the programs or policies if needed.

Confidentiality

Your name, identifiable information and anything you say or do in this study will be entirely confidential. Your information and data collected will be stored in a password protected file on my personal computer and the audio files will be stored in a locked cabinet at home. All the identifiable information will be removed. Only me (Behi Ahani), Margaret Coombes, and Leah Douglas will have access to the raw data. I am the only one who has access to the computer password and the locked cabinet at home. All the raw data on the computer will be deleted; all the paper copies of the raw data will be placed in a confidential shredding at my office and the audio files will be erased after the completion of this study. This has been approved by MCFD.

Participation

Your participation is totally voluntary and you can withdraw anytime you wish during this study. If you withdraw, the data you provided to me will be destroyed unless you allow us to use the data. I would like to mention that you can refuse to answer some questions if you do not feel comfortable; however, you can stay in the study.

Study Results

The result of this study can be shared with you. If you wish to have the result of the study, you can contact me and I will send it to you via email. The results will be published as part of my MSW major paper, and may be presented in academic and community forums and meetings.

Questions

If you have any questions or require further information about this study before or during participation, you can contact me (Behi Ahani-Masooleh) at the University of the Fraser Valley at [redacted] . If you have any ethical concerns about this research study, contact Adrienne Chan, AVP of Research, Engagement, and [redacted] . This ethics of this project have been reviewed and approved by the UFV Human Research Ethics Board.

Consent Form

By signing below I agree to participate in this study, titled Appropriateness of Assessment and Treatment Interventions Offered to Immigrant and Refugee Children and Youth with Mental Health Issues.

I have read the information presented in the letter of informed consent being conducted by (Behi Ahani-Masooleh and faculty) at the University of the Fraser Valley. I have had the opportunity to ask questions about my involvement in this study and to receive any additional details.

I understand that I have the right to withdraw from the study at any time and that confidentiality and/or anonymity of all results will be preserved. If I have any questions about the study, I should contact (Behi Ahani-Masooleh [redacted] If I have any ethical concerns about this research study, I should contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at [redacted]

Please note the face to face or phone interview will be recorded on an audio tape. If you agree to be audio taped, please put an X in the box. ☐

Name (please print) _____

Signature _____

Date _____

Once signed, you will receive a copy of this consent form.

Appendix D

Questionnaire

Understanding Specific Needs of Minority Children and Youth with Mental Health Issues

Your perspectives, experiences, and feedback about the cultural appropriateness of the treatment interventions provided to the minority children and youth with mental health are very valuable. Your information is anonymous and your answers will be entirely confidential. Please note that you are not obligated to answer the questions that may cause you any discomfort.

Please answer the following questions to the best of your ability.

Please put a check mark beside your answers.

1. Cultural beliefs can influence ethnic minority's understanding of their mental health illness.

- True
- False

2. Cultural beliefs can influence ethnic minority's selection of treatment.

- True
- False

3. Cultural competency, which is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations, is a requisite condition for good clinical practice.

- True

- False

4. Linguistic and cultural barriers prevent refugee and immigrant children and youth from receiving proper treatment.

   -True
   -False

5. DSM-5 is an appropriate diagnostic classification and diagnostic tool for treatment of the ethnic minority children and youth.

- True
- False

6. Having a holistic approach that recognizes cultural differences is crucial in treatment of ethnic minority children and youth.

- True
- False

7. Culturally sensitive screening tools and assessments are essential for assessing the mental health of ethnic minority populations.

- True
- False

8. How confident do you feel in providing your diverse refugee and immigrant children and youth with culturally appropriate interventions?

- Very confident
- Somewhat confident
- Not confident
- Prefer not to say

9. Approximately, what percentage of your clients are refugees or immigrants?

- 0-25 %
- 26-50%
- 51-75%
- 76-100%

10. Do all the refugee and immigrant children and youth you work with speak English? If not, please go to the next question.

- Yes
- No
- Some English

11. What sources do you use for interpretation? (Choose as many as apply).

- Myself if I speak the same language as my client
- Parents/Siblings
- Relatives/friends
- Professional Interpreter
- Other staff at your agency who can speak the client's language
- Other (please specify): _____

12. Have you had any education and training for cross-cultural psychiatry in the last 5 years?

- Yes
- No
- Yes, but more than five years ago

13. The areas of skill required for effective multicultural practice are: (Choose as many as apply)

- Cultural awareness
- Knowledge acquisition
- Skill development
- Direct ongoing learning
- All of the above
- None of the above

14. What sources do you use to gather cultural information for your assessment of the minority children and youth you are helping? (Choose as many as apply).

- Children and youth themselves
- Parents/legal guardians
- Siblings/family
- Relatives/friends
- Foster parents
- School or other agencies working with the clients
- Referral sources

- Other (please specify): _____

Please answer the next two questions.

1. What treatment models do you apply in working with ethnic minority children and youth?

2. In your practice, what challenges and barriers have you experienced that have prevented you from providing your clients with culturally appropriate treatment interventions?

This section asks questions about you. This information is necessary because it will help me with the objective of my research. The data you share with us will not be used to personally identify you, and will not be passed on to anyone else. If you prefer not to answer these questions, you can leave it blank.

Ethnicity:

- Aboriginal
- Black
- Caucasian
- Latin American
- South Asian
- Asian
- Middle Eastern
- Other visible minority (please specify): _____

Educational background:

- Nurse
- Social worker
- Clinical counselor
- Psychologist
- Other disciplines (please specify): _____

Other languages spoken

- French
- Spanish
- Arabic
- Mandarin
- Cantonese
- Farsi
- Other (s) (please specify): _____

Years of experience in Mental Health practice:

- 0-5
- 6-10
- 11-15
- 16-20
- 21-25
- 25 or more

Thank you for taking the time to complete this survey.

Appendix E

Interview Questions

- How do define cultural humility?
- Do you think mental health services at your agency is inviting for refugee and immigrant children and youth with mental health issues?
- What model of treatment do you think is more appropriate in working with refugee and immigrant children and youth?
- How do you feel about developing appropriate and effective interventions in treatment of minority children and youth with mental health issues?
- How can we increase our knowledge about the diverse clients we serve?
- What are some of the barriers of refugee and immigrant children and youth in accessing treatment for their mental health issues?
- How do you educate yourself about the culture of the diverse clients you are working with?
- What other roles do you play in helping ethnic minority children and youth in addition to the role of therapist?

Appendix F

Sponsor Letter

Subject: Re: Conducting a Research Study by Behi-Ahani-Masooleh, an MSW Student at UFV

Dear (sponsor):

I am writing to let you know about an opportunity to participate in a research study about the appropriateness of the assessments and treatment interventions offered to the refugee and immigrant children and youth with mental health issues. My research topic is: Do mental health clinicians provide immigrant and refugee children and youth with appropriate assessment and interventions based on their specific needs?

This study is conducted by me, Behi-Ahani-Masooleh at the University of the Fraser Valley. This research study is part of my MSW studies. I am hoping that through your assistance, I will be able to have a chance to recruit your front line clinicians (social workers, clinical counselors, nurses, and psychologists who work directly with minority children) to have their perspectives, experiences, and feedback regarding the assessment of the diagnosis and intervention methods offered to the minority children for their treatment. I would like you to send my invitation to the managers or team leaders of the two offices in Burnaby and to one office in Port Moody and ask them to forward this invitation to their clinicians. The clinicians who are interested in participating in this research can contact me directly through my email. The participants will be asked to participate in a survey or interview. The staff information will be confidential and not

shared with anyone without his/her permission. Please note that the staff participation in this study is voluntary and they can withdraw anytime they wish. If you would like additional information about this study, please contact me at [redacted]. Please note that the ethics of this research have been reviewed and approved by the UFV Human research Ethics Board. Please click on the links below to see the fully informed consent form and the survey and interview. The volunteer clinicians will be asked to sign the fully informed consent form.

Links:

Fully Informed Consent Form

Survey

Thank you again for considering this research opportunity